



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HCA CORPUS CHRISTI MEDICAL CENTER

Respondent Name

FACILITY INSURANCE CO

MFDR Tracking Number

M4-05-3866

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JANUARY 25, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%."

Amount in Dispute: \$86,518.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Requestor asserts it is entitled to reimbursement in the amount of \$90,218.25, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges...The hospital failed to obtain preauthorization for more than the three days of hospital stay. Three days was preauthorized...the hospital has failed to demonstrate that the condition was emergent...Furthermore, there is a substantial possibility that the additional stay beyond three days was the result of the hospital's error in administering a drug...Following the administration of the drug, the employee was admitted to ICU. He was then transferred to the cardiac care unit for a 10-day stay...While an employee may be entitled to reimbursement of additional income benefits that resulted from the medical malpractice of a provider, it would be ludicrous to suggest that the provider is entitled to be reimbursed for the consequences of the provider's own error. ..Thus, in addition to the failure to obtain preauthorization, the bill after the first three days of admission should be denied for the reason that the services did not naturally result from the compensable injury..."

Respondent's Supplemental Position Summary Dated April 26, 2017: Respondent submits this Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV...Based upon Respondent's initial and all supplemental responses, and under the Division's obligation to adjudicate the payment, under the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded under the general per diem payment under 28 TEX. ADMIN. CODE §134.401 (repealed). Otherwise, the Division should determine the proper audited charges under Division audit obligations and rules."

Responses Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
January 27, 2004 through March 29, 2004	Inpatient Hospital Services	\$86,518.27	\$10,834.02

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 requires preauthorization for non-emergency inpatient hospitalizations.
3. 28 Texas Administrative Code §133.1 defines a medical emergency.
4. 28 Texas Administrative Code §134.401, 22 Texas Register 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital for the date of admission in dispute.
5. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services."
6. The services in dispute were reduced / denied by the respondent with the following reason codes:
Explanation of Benefits
 - A-Payment denied since you failed to obtain preauthorization for treatment(s) and/or services that require preauthorization.
 - O-Previous recommended amount has not been changed.
 - F-Payment based on the assigned per diem amount per the 1997 Acute Inpatient Hospital Fee Guideline.
 - M-Payment reduced according to fair and reasonable.
 - G-Payment for these services is included in the per diem amount.
 - S-Previously recommended amount has been amended as indicated.
 - F-The technical component exceeds the maximum allowable fee for the Texas workers' compensation medical fee guidelines.
5. Dispute M4-05-3866 History
 - The division originally issued a decision on May 3, 2005.
 - The dispute decision was appealed to the District Court.
 - The 126th Judicial District remanded the dispute to the division pursuant to an agreed order of remand D-1-GN-08-000102 dated November 29, 2016.
 - As a result of the remand order, the dispute was re-docketed at the division's medical fee dispute resolution section.
 - M4-05-3866-02 is hereby reviewed.

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Does a preauthorization issue exist?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the Division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that “Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection...” 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c) (6) (A) (i) states “to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold.” Furthermore, (A) (v) of that same section states “Audited charges are those charges which remain after a bill review by the insurance carrier has been performed.” Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c) (6) (A) (v); therefore the audited charges equal \$120,291.00. The division concludes that the total audited charges exceed \$40,000.
2. The requestor in its position statement presumes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services.” The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 Texas Administrative Code §134.401(c) (6).
3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds \$40,000, the stop loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The requestor failed to demonstrate that the particulars of the admission in dispute constitutes unusually costly services; therefore, the division finds that the requestor failed to meet 28 Texas Administrative Code §134.401(c) (6).
4. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon “A-Payment denied since you failed to obtain preauthorization for treatment(s) and/or services that require preauthorization.”

28 Texas Administrative Code §134.600(h) states “The non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions including the principal scheduled procedure(s) and the length of stay.”

28 Texas Administrative Code §134.600(i) states “The health care requiring concurrent review for an extension for previously approved services includes: (1) inpatient length of stay.”

28 Texas Administrative Code §133.1(a)(7)(A), defines “a medical emergency consists of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part.”

A review of the submitted medical records finds the claimant was admitted to hospital due to a spinal headache and risks of a dural leak. The records support emergent care until February 9, 2004. Therefore, preauthorization was not required from January 27, 2004 to February 9, 2004. For dates of service after February 9, 2004, no evidence that preauthorization was obtained; therefore, a preauthorization issue exists in this case.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” The length of stay was sixty two (62) days; however, documentation supports that the Carrier pre-authorized a length of stay of three days in accordance with 28 Texas Administrative Code Rule §134.600 and emergent care was rendered for an additional ten days. Consequently, the per diem rate allowed is \$1,118.00 times thirteen days equals \$14,534.00.
 - 28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).” Review of the requestor’s medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A):

Code	Itemized Statement Description	No. of Units	UNITS / Cost Per Unit	Total Cost	Cost + 10%
278	Dura Sub 6.0cm X 8cm	1	Although requestor submitted an invoice, the lot number does not match the lot number of implant listed on Operating Room Implant Register report; therefore, no support for cost/invoice.	\$0.00	\$0.00
TOTAL ALLOWABLE				\$0.00	

- 28 Texas Administrative Code §134.401(c)(4)(B) allows that “When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619).” A review of the submitted hospital bill finds that the requestor billed \$11,985.00 for revenue code 612-MRI-Spine. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 612 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(B) allows that “When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399).” A review of the submitted hospital bill finds that the requestor billed \$63.00 for revenue code 390-Blood/Storage Processing and \$845.00 for revenue code 391-Blood Administration. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue codes 390 and 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended

The division concludes that the total allowable for this admission is \$14,534.00. The respondent issued payment in the amount of \$3,699.98. Based upon the documentation submitted, additional reimbursement can be recommended of \$10,834.02.

Conclusion

For the reasons stated above, the division concludes that the services in dispute are not eligible for the stop-loss method of reimbursement, that a pre-negotiated rate does not apply, and that application of 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*, results in the total allowable reimbursement. Based upon the documentation submitted, the requestor's Table of Disputed Services, and reimbursement made by the respondent, the amount ordered is \$10,834.02.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$10,834.02 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

		05/05/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.